Benton-Franklin Health District

2018 Health Disparities Report

For Benton & Franklin Counties

December 2018

Benton-Franklin Health District
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Introduction & Background

Introduction

The 2018 Health Disparity Report for Benton and Franklin Counties compiles data from multiple sources and identifies disparities between different population groups in various health outcomes and associated risk factors. This report was compiled with the purpose of highlighting the various health disparities that exist in the bi-county region in order to better address inequities and work towards achieving health equity throughout the community.

Everyone is striving to achieve and maintain optimal health where they live, work, and learn. Poor health affects length of life and, even more importantly, quality of life. It is becoming increasingly clear that health outcomes are greatly influenced by social, economic, and environmental conditions and are not just determined by genetics and clinical care. In other words, place matters. Health data is one way to measure the health of a community. The challenge is that health outcomes are not the same across the country, or even within counties or cities. Identifying the populations at higher risk can be a first step in determining the social, economic, and environmental conditions that put people at higher risk. Increased awareness of disparities can help to more successfully address these barriers to health, particularly those barriers that are systematic and preventable.

Health Equity

Health Equity works to optimize conditions so that everyone in the community has the opportunity to attain their highest level of health and achieve positive health outcomes. Health outcomes are influenced by a multitude of factors other than genetics and biology, including behavioral, environmental, and social factors. These external factors, known as **Social Determinants of Health** (SDOH) include housing, education, income, healthcare, public safety, and food access. Race, culture, and gender identity are forces in determining how these social determents are distributed. Certain population groups are disproportionately impacted by these factors and are, therefore, at a higher risk of various negative health outcomes and adverse health disparities. **Health Disparities** are differences in health status between groups of people related to SDOH such as race, gender, income, or geographic region. It is important to recognize that differences in health status related to race, culture, and gender identity may in fact reflect systematic inequities in how social determinants like housing, food access, and education are distributed. Health disparities are one way to measure progress toward achieving health equity; fewer health disparities means greater health equity.

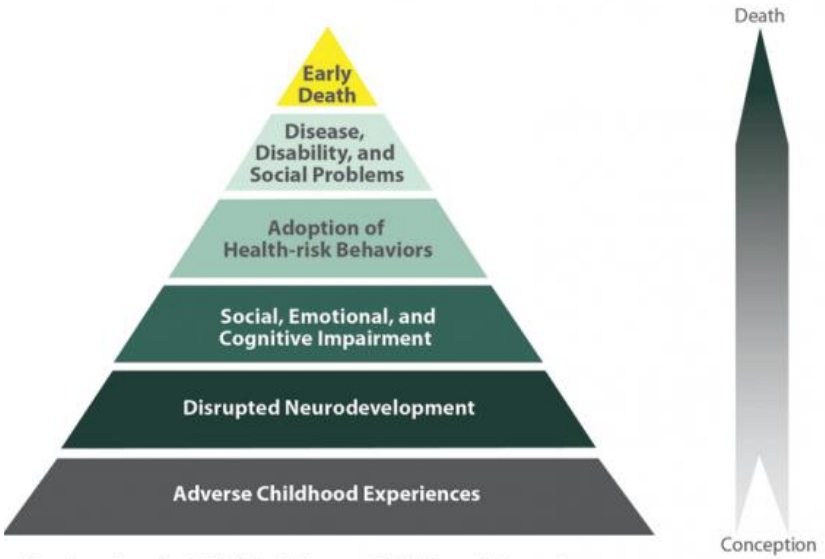
Adverse Childhood Experiences (ACEs) and Chronic Disease

Research over the last couple of decades has shed light on the influence that childhood experiences have on the lifelong health and well-being of individuals. The foundational research in this area refers to negative childhood experiences as **Adverse Childhood Experiences** (ACEs) and has identified a specific list of ACEs that link to common and serious chronic health conditions, risky health behaviors, and early death. ACEs have been linked to health outcomes like obesity, diabetes, depression, suicide attempts, sexually transmitted diseases (STDs), heart disease, cancer, strokes, and broken bones; behavioral outcomes like smoking, alcoholism, and substance abuse; and life potential like lower graduation rates and academic achievement. The identified list of ACEs are broken up into eight categories: physical abuse, sexual abuse, emotional abuse, mental illness in the home, substance abuse in the home, household domestic violence, incarcerated household member, and divorce or separation of parents.

Findings from the Center for Disease Control and Prevention's (CDC) latest research show that five sociodemographic groups reported higher exposure to ACEs and were, therefore, more likely to have been exposed to adversity earlier in life. Those groups are:

- Black, Hispanic, or multicultural individuals
- People with less than a high school education
- People who earn less than $15,000 per year
- People who are unemployed or unable to work
- People who identify as LGBTQ

While a higher ACE score does not necessarily result in poor health and life outcomes, the research is clear that risk factors for chronic conditions increase along with the number of ACEs. The more ACES a child experiences growing up, the higher the risk that child has for experiencing these outcomes. Based on this premise, the BFHD Disparities Report chose to look at available data related to ACEs and demographic disparities as part of the overall conversation around health equity.



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention (June 2016) ACE Study.
2. Bergland, C. (Sep 2018) 5 Factors Linked to Higher Risk of Early Life Adversity. *Psychology Today*.

Methodology

This report is not an exhaustive list of all health disparities that exist in Benton and Franklin Counties, throughout the state of Washington, or spanning the United States. In addition, some of the health disparities highlighted in this report may have better or worse rates on a state or national level. In determining which health disparities to highlight in this report, the assessment team reviewed available data sources to identify indicators related to known health outcomes and issues in Benton and Franklin counties. Data sets from both counties were combined to provide a more holistic account of the region and the bi-county data was then analyzed and converted into relative risk ratios by population groups.

The interest population groups chosen by the assessment team based on demographic categories were gender (male and female), race (white and people of color, not including Hispanic or Latino), ethnicity (Hispanic or Latino), and sexual orientation (LGBTQ). For statistical analysis, white, straight males were used as the reference population group for each demographic category, except in the case of the white and male population groups, in which the rates were compared to people of color, Hispanics/Latinos, and females respectively. The assessment team used white males as the general reference population due to the large population base and historical foundation of research, which lends that population group well to statistical comparisons. Similarly, in the event of a possible disparity between population groups other than the original reference group of white, straight male, the minority population groups were used as a comparative group when a disparity existed. For example, females in the white and people of color population groups had similar rates of smoking while pregnant, both of which were significantly higher than the rates of females in the Hispanic/Latino population group. In this case, the Hispanic/Latino females became the reference group, demonstrating an adverse disparity for white women and women of color.

Once the relative risk ratios were calculated for each indicator, any indicator that did not show a statistically significant difference in rates between the various population and reference groups was eliminated. The data analysis used a chi-squared test for proportions with a p-value of less than .05, resulting in a 95% confidence interval. The assessment team then chose to narrow down the results further by eliminating indicators that had relative risk ratios between .75 and 1.5, as these had been classified as lower magnitude disparities. While not highlighted under the *Key Findings* section of this report, in order to provide a transparent and complete picture of the health disparities that exist in the bi-county region, this report does contain a list of all the indicators that yielded statistically significant results, including the lower magnitude disparities, in the *Data Tables* section.

To determine which health disparities to highlight in the *Key Findings* section of this report, the assessment team reviewed the local 2016 Community Health Needs Assessment and the 2018 Washington State Health Assessment, specifically using the key issues identified in those reports as guidance. Those key issues from the state and local health assessment are as follows:

- Healthy weight with a focus on healthy eating and active living
- Tobacco use
- Drug and alcohol use
- Mental health
- Child immunizations
- Diabetes
- Housing and homelessness
- Health care access

As a result, indicators that related to the key issues identified through the state or local health assessments and met the statistical significance threshold explained previously were included in the *Key Findings* section of this report.

Crowd of residents and visitors enjoying an annual community event in Prosser, Benton County Washington.

Key Findings

MALES

Compared to Benton and Franklin County residents who identify as female, residents who identify as male:

- Early through late adulthood have a **higher** likelihood of dying by suicide
- Middle and late adulthood have a **higher** likelihood of diabetes related hospitalization and a **higher** likelihood of heart disease related hospitalization
- Adults have a **higher** likelihood of being told they have cardiovascular disease by a healthcare provider.

FEMALES

When compared to Benton and Franklin County residents who identify as male, residents who identify as female:

- Adolescents have a **higher** likelihood of seriously contemplating suicide within the past 12 months
- Middle to late adulthood have a **higher** likelihood of a suicide related hospitalization
- Adults have a **higher** likelihood of experiencing mental distress (14 or more days of poor mental health during the past 30 days)
- Older adults have a **higher** likelihood of living below 100% of the poverty line

LGBTQ

When compared to Benton and Franklin County residents who identify as straight, residents who identify as LGBTQ:

- Adolescents have a **higher** likelihood of being bullied in the last month
- Adolescents have a **higher** likelihood of being physically hurt on purpose by an adult
- Adolescents have a **lower** likelihood of having opportunities for prosocial involvement in the family setting
- Adolescents have a **higher** likelihood of smoking tobacco and a **higher** likelihood of smoking electronic cigarettes in the past 30 days
- Adolescents have a **higher** likelihood of using alcohol and a **higher** likelihood of using marijuana in the past 30 days
- Adolescents have a **higher** likelihood of seriously contemplating suicide during the past 12 months
- Adolescents have a **higher** likelihood of living somewhere other than their own families' homes
- Adolescents have a **higher** likelihood of being purposefully hurt by a romantic partner

STRAIGHT

Compared to Benton and Franklin County residents who identify as LGBTQ, residents who identify as straight:

- Adults have a **higher** likelihood of being told by a health care provider that they have cardiovascular disease.

PEOPLE OF COLOR

When compared to Benton and Franklin County residents who identify as White, residents who identify as People of Color:

- Young children have a **lower** likelihood of being enrolled in early education programs
- Adolescents have a **higher** likelihood of seriously contemplating suicide within the past 12 months
- Adolescents have a **higher** likelihood of living somewhere other than their own families' homes

When compared to Benton and Franklin County residents who identify as Hispanic or Latino, residents who identify as People of Color:

- Adolescents have a **higher** likelihood of being bullied in the last month
- Adolescents have a **higher** likelihood of smoking tobacco in the last 30 days
- Middle to late adulthood have a **higher** likelihood of dying by suicide and a **higher** likelihood of drug-related death
- Adults have a **higher** likelihood of currently smoking tobacco
- Females have a **higher** likelihood of smoking during pregnancy

HISPANIC OR LATINO

When compared to Benton and Franklin County residents who identify as White, residents who identify as Hispanic or Latino:

- Young children have a **lower** likelihood of being enrolled in early education programs
- Adolescents have a **higher** likelihood of using alcohol in the last 30 days
- Adults have a **lower** likelihood of having health insurance
- Have a **higher** likelihood of living 100% below the poverty line

When compared to Benton and Franklin County residents who identify as People of Color, residents who identify as Hispanic or Latino:

- Adults have a **higher** likelihood of being obese

WHITE

When compared to Benton and Franklin County residents who identify as Hispanic or Latino, residents who identify as White:

- Early through late adulthood have a **higher** likelihood of suicide related hospitalization and a **higher** likelihood of dying by suicide
- Have a **higher** likelihood of a drug-related death
- Adults have a **higher** likelihood of currently smoking tobacco
- Adults have a **higher** likelihood of being told they have cardiovascular disease by a healthcare provider.
- Females have a **higher** likelihood of smoking during pregnancy

When compared to Benton and Franklin County residents who identify as People of Color, residents who identify as White:

- Adults have a **higher** likelihood of being obese

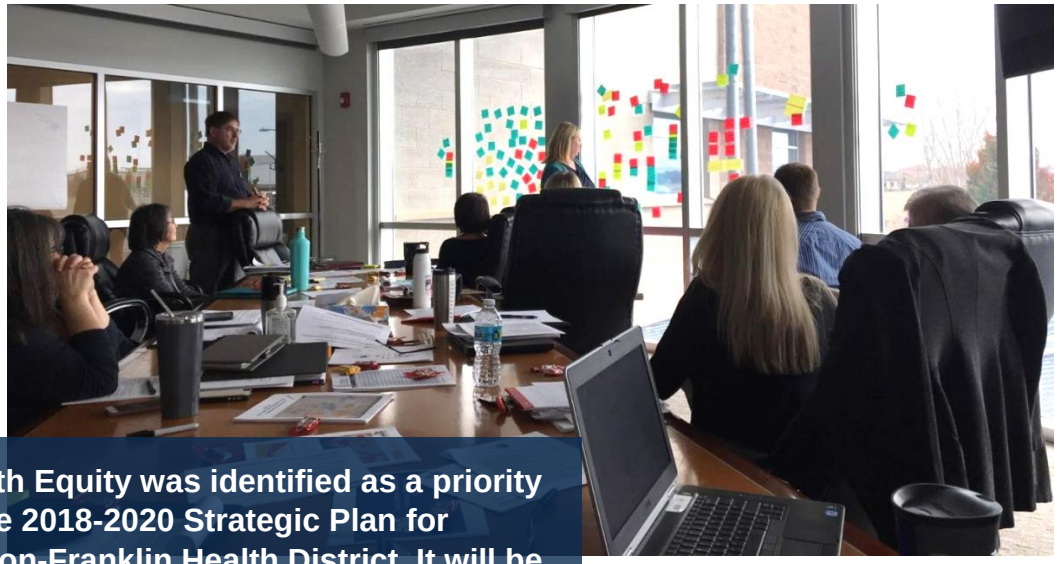
Call to Action

Identify and Monitor Disparities

Our community must first identify and understand the various health disparities that exist within our unique, bi-county region. Disparities that are well established on a national level or prominent on the East Coast may not apply to Benton and Franklin Counties. Our region, however, does have health disparities related to race, ethnicity, sex, and sexual orientation that need to be considered in order to provide quality, effective services and programs to all members of the community. Identification of issues present in the community is the first step toward meaningful action to achieve health equity. Mobilizing and monitoring timely data enables the community to more effectively implement and evaluate efforts to reduce disparities.

Strive for Internal Improvements to Address Inequities

If we at the Health District wish to make lasting, impactful changes to the health and well-being of local residents, we must begin with internal efforts to ensure there is a foundational focus on health equity that permeates throughout all of our departments, programs, and services for both the public and our own employees. BFHD is dedicated to the goal of improving health equity and is making internal changes to ensure it becomes a piece of our foundational principles. BFHD has incorporated health equity into its 2018-2020 Strategic Plan that guides the agency's work and focus for the next three years. The newly established Health Equity Sub-Committee leads the agency's efforts to address health equity internally and with our community partners. Internal efforts underway that impact the public include ensuring that our services are culturally and linguistically appropriate for our community, developing ourselves as a Trauma Informed Organization resource for the community, and using health equity related data, like this disparities report, to inform our decisions and influence our programs and services.



Health Equity was identified as a priority in the 2018-2020 Strategic Plan for Benton-Franklin Health District. It will be a guiding focus for the agency over the next three years.

Educate Stakeholders and Policy Makers about Local Disparities

Educating our community partners, especially decision and policy makers, about the reality of health disparities in our local community is paramount to addressing health equity. Helping stakeholders understand concepts and relate their work to things like Social Determinants of Health, institutionalized inequities, and local disparities facilitates an environment that promotes a health-in-all-policies approach.

Seek Interventions that Promote Inter-Sector Collaboration to Support Health Equity

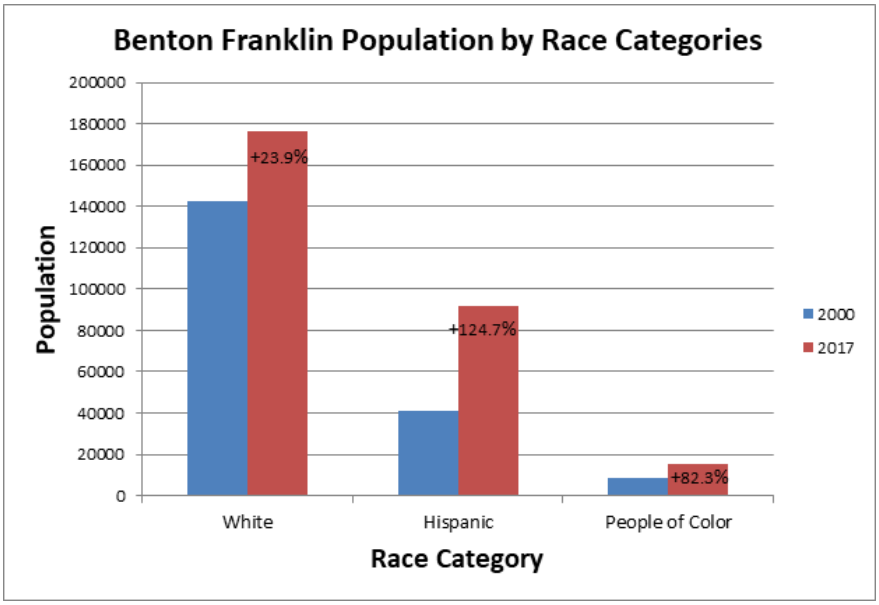
Health-in-all-policies initiatives seek to improve the health of a community through a collaborative approach that incorporates health considerations into policies and practices throughout various sectors and organizations. We must work with other sectors to effectively address the often complex issues and deep rooted inequities that create heath disparities. The collaboration should also include communities affected by inequities to incorporate their voice into the decision-making process.

Photo credit: Bob Brawdy, Tri-City Herald.

International Walk to School Day event in Pasco, Washington. Collaboration between Safe Kids Benton-Franklin, Pasco Police Department, Emerson Elementary School, and Benton-Franklin Health District to promote healthy behaviors and exercise.

Community Demographics

Benton and Franklin Counties have a total population of approximately 283,000 people. Each of the three main municipalities that make up the Tri-Cities are located within one of these two counties; Kennewick and Richland within Benton County and Pasco within Franklin County. There are numerous other smaller cities located within this jurisdiction including Prosser, Connell, Eltopia, Benton City, West Richland, Finley, Mesa, Basin City, and Kahlotus. While the population remains predominantly White, there is a significant Hispanic/Latino population that has more than doubled over the past two decades.



By Race and Ethnicity	Benton and Franklin County		
	Earliest Year (2000) # (% of total population)	Recent Year (2017) # (% of total population)	Percent Change Since 2000 % increase of population
Total Population	191,821	283,830	48%
White, Non-Hispanic	142,552 (74%)	176,680 (62%)	24%
Black or African American, Non-Hispanic	2,739 (1%)	4,860 (2%)	77%
American Indian and Alaska Native, Non-Hispanic	1,264 (1%)	1,868 (1%)	48%
Asian and Pacific Islander, Non-Hispanic	4,428 (2%)	8,639 (3%)	95%
Hispanic or Latino	40,838 (21%)	91,783 (32%)	125%

Relative Risk Ratios

The Centers for Disease Control and Prevention defines risk ratios as the comparison of risk level of certain health factors or outcomes for one group with the risk level among another group. This can be used to compare various demographic groups such as race, ethnicity, age, sex, sexual orientation, etc. For example, comparing how many Hispanics live below the poverty line to how many White people live below the poverty line. This ratio is determined by dividing the risk level in the interest group with the risk level in the comparison group. Using the previous example, the following formula would apply:

$$\frac{\text{Risk of Hispanic people living below the poverty line (Rate for the interest group)}}{\text{Risk of White people living below the poverty line (Rate for the comparison group)}}$$

A risk ratio of approximately 1.0 means the risk level is similar between the two groups. The farther away that number moves from 1.0, either up or down, indicates there is either an increased risk (higher than 1.0) or a lower risk (lower than 1.0) for the interest group from the comparison group. In the example used above, the formula indicates that Hispanics are 2.67 times more likely than Whites to live below the poverty line.

3. The Centers for Disease Control and Prevention. (May 2012). Lesson 3: Measures of Risk. In *Principles of Epidemiology in Public Health Practice* (3rd ed.). Atlanta, Georgia: U.S. Department of Health and Human Services.

Tables of Statistically Significant Disparities

Relative Risk Ratio Table

The data presented in this table shows the relative risk ratios for **all** of the indicators that showed any degree of statistical significance, regardless of whether it was highlighted on the *Key Findings* section.

Things to know when reading this table:

- If a number is higher or lower than 1.0, it just means there is a statistically significant difference. It does not mean good or bad; that depends on the indicator itself.
- If a risk ratio is less than 1.0, that means the interest population group has a lower likelihood of experiencing that indicator.
- If the risk ratio is greater than 1.0, that means the interest population group has a higher likelihood of experiencing that indicator.
- "NS" indicates the data point was not stratified by age.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
FEMALES		
Youth (grade 8, 10, 12) report being bullied in the last month	13-17	Females ages 13-17 are 1.4 times as likely as Males to report being bullied in the last month.
Youth (grades 8, 10, 12) report ever being physically hurt on purpose by an adult	13-17	Females ages 13-17 are 1.15 times as likely as Males to report ever being physically hurt on purpose by an adult.
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	Females ages 13-17 are 0.92 times as likely as Males to report opportunities for prosocial involvement in the family setting.
Youth (grades 8, 10, 12) report eating 5 or more fruits/vegetables daily	13-17	Females ages 13-17 are 0.76 times as likely as Males to report eating 5 or more fruits/vegetables daily.
Youth (grades 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	Females ages 13-17 are 0.8 times as likely as Males to report engaging in 1 or more hours of physical activity 5 or more days per week.
Youth (grades 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	Females ages 13-17 are 1.87 times as likely as Males to report seriously considering attempting suicide during the past 12 months.
Suicide-related hospitalization (nonfatal) rate per 100,000 residents	35-64	Females ages 35-64 are 1.68 times as likely as Males to be hospitalized for nonfatal suicide attempts.
Older adults (age 65 and older) living below 100% of poverty	65+	Females age 65+ are 1.73 times as likely as Males to be living below 100% of poverty.
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	65+	Females age 65+ are 1.61 times as likely as Males to be hospitalized for a fall (fatal and nonfatal).
Alzheimer's death rate per 100,000 residents	65+	Females age 65+ are 2.19 times as likely as Males to die of Alzheimer's disease.
Residents living below 100% of poverty	NS	Females of all ages are 1.23 times as likely as Males to be living below 100% of poverty.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
FEMALES (continued)		
Civilian adults (age 16 and older) currently employed	NS	Females (age 16 and older) are 0.84 times as likely as Males to be currently employed.
Adults report mental distress (14 or more days of poor mental health during the past 30 days)	NS	Females age 18+ are 1.93 times as likely as Males to report mental distress (14 or more days of poor mental health during the past 30 days).
Adults report their general health is excellent, very good, or good during the past 30 days	NS	Females age 18+ are 0.95 times as likely as Males to report their general health is excellent, very good, or good during the past 30 days.
MALES		
High school graduation rate (5-year cohort)	13-17	Males ages 13-17 are 0.92 times as likely as Females to graduate high school (5-year cohort).
Youth (grade 8, 10, 12) report 3 hours or less of screen time for fun on school days	13-17	Males ages 13-17 are 0.89 times as likely as Females to report 3 hours or less of screen time for fun on school days.
Youth (grade 8, 10, 12) report using electronic cigarettes in the past 30 days	13-17	Males ages 13-17 are 1.21 times as likely as Females to report using electronic cigarettes in the past 30 days.
Youth (grade 8, 10, 12) report having had a dental checkup, exam or cleaning in the past 12 months	13-17	Males ages 13-17 are 0.96 times as likely as Females to report having had a dental checkup, exam or cleaning in the past 12 months.
Youth (grade 8, 10, 12) at a normal weight (between the 5th and 95th percentile for BMI)	13-17	Males ages 13-17 are 0.89 times as likely as Females to be a normal weight (between the 5th and 95th percentile for BMI).
Civilian adults report having health insurance	18-34	Males ages 18-34 are 0.94 times as likely as Females to report having health insurance.
Diabetes-related hospitalization (fatal and nonfatal) rate per 100,000 residents	18-34	Males ages 18-34 are 1.44 times as likely as Females to be hospitalized for diabetes (fatal and nonfatal).
Death rate per 100,000 residents	18-34	Males ages 18-34 are 2.8 times as likely as Females to die.
Suicide Rate per 100,000 residents	18-34	Males ages 18-34 are 5.67 times as likely as Females to die by suicide.
Civilian adults report having health insurance.	35-64	Males ages 35-64 are 0.96 times as likely as Females to report having health insurance..
Diabetes-related hospitalization (fatal and nonfatal) rate per 100,000 residents	35-64	Males ages 35-64 are 1.83 times as likely as Females to be hospitalized for diabetes (fatal and nonfatal).
Heart disease hospitalization (fatal and nonfatal) rate per 100,000 residents	35-64	Males ages 35-64 are 1.93 times as likely as Females to be hospitalized for heart disease (fatal and nonfatal).
Suicide rate per 100,000 residents	35-64	Males ages 35-64 are 2.83 times as likely as Females to die by suicide.
Diabetes-related hospitalization (fatal and nonfatal) rate per 100,000 residents.	65+	Males age 65+ are 2.11 times as likely as Females to be hospitalized for diabetes (fatal and nonfatal).
Heart disease hospitalization (fatal and nonfatal) rate per 100,000 residents.	65+	Males age 65+ are 1.31 times as likely as Females to be hospitalized for heart disease (fatal and nonfatal).
Suicide rate per 100,000 residents..	65+	Males age 65+ are 8.27 times as likely as Females to die by suicide.
Adults (age 25 and older) with more than a high school education	NS	Males age 25 and older are 0.99 times as likely as Females to have more than a high school education.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
MALES (continued)		
Adults ever told by a health care provider that they have cardiovascular disease	NS	Males age 18+ are 1.92 times as likely as Females to have ever been told by a health care provider that they have cardiovascular disease.
Adults report currently smoking	NS	Males age 18+ are 1.38 times as likely as Females to report currently smoking.
PEOPLE OF COLOR		
Babies born at low birth weight (less than 2500 grams)	0-4	Children of color ages 0-4 are 1.32 times as likely as White children to be born at low birth weight (less than 2500 grams).
Children age 3-4 enrolled in early education programs	0-4	Children of color age 3-4 are 0.54 times as likely as White children be enrolled in early education programs.
Youth (grade 8, 10, 12) report being bullied in the last month	13-17	People of color ages 13-17 are 1.55 times as likely as Hispanics to report being bullied in the last month.
Youth (grade 8, 10, 12) report having an adult to turn to for help when feeling sad or hopeless	13-17	People of color ages 13-17 are 0.89 times as likely as White youth to report having an adult to turn to for help when feeling sad or hopeless.
Youth (grades 8, 10, 12) report ever being physically hurt on purpose by an adult	13-17	People of color ages 13-17 are 1.27 times as likely as White youth to report ever being physically hurt on purpose by an adult.
Youth (grades 8, 10, 12) report parent(s) do not set clear rules	13-17	People of color ages 13-17 are 1.33 times as likely as White youth to report having parent(s) who do not set clear rules.
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	People of color ages 13-17 are 0.87 times as likely as White youth to report opportunities for prosocial involvement in the family setting.
High school graduation rate (5-year cohort)	13-17	People of color ages 13-17 are 0.94 times as likely as White youth to graduate High school (5-year cohort).
Youth (grade 8, 10, 12) report eating 5 or more fruits/vegetables daily	13-17	People of color ages 13-17 are 1.29 times as likely as White youth to report eating 5 or more fruits/vegetables daily.
Youth (grade 8, 10, 12) report drinking no sugary beverages in the past 7 days at school	13-17	People of color ages 13-17 are 0.91 times as likely as White youth to report drinking no sugary beverages in the past 7 days at school.
Youth (grade 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	People of color ages 13-17 are 0.92 times as likely as White youth to report engaging in 1 or more hours of physical activity 5 or more days per week.
Youth (grade 8, 10, 12) report 3 hours or less of screen time for fun on school days	13-17	People of color ages 13-17 are 0.89 times as likely as White youth to report 3 hours or less of screen time for fun on school days.
Youth (grade 8, 10, 12) report smoking tobacco in the past 30 days	13-17	People of color ages 13-17 are 1.43 times as likely as Hispanic youth to report smoking tobacco in the past 30 days.
Youth (grade 8, 10, 12) report using electronic cigarettes in the past 30 days	13-17	People of color ages 13-17 are 1.26 times as likely as White youth to report using electronic cigarettes in the past 30 days.
Youth (grade 8, 10, 12) report using marijuana in the past 30 days	13-17	People of color ages 13-17 are 1.4 times as likely as White youth to report using marijuana in the past 30 days.
Youth (grade 8, 10, 12) report having had a dental checkup, exam, or cleaning in the past 12 months	13-17	People of color ages 13-17 are 0.91 times as likely as White youth to report having had a dental checkup, exam, or cleaning in the past 12 months.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
PEOPLE OF COLOR (continued)		
Youth (grade 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	People of color ages 13-17 are 1.76 times as likely as White youth to report seriously considering attempting suicide during the past 12 months.
Youth (grade 8, 10, 12) who live somewhere other than their own families' home	13-17	People of color ages 13-17 are 1.96 times as likely as White youth to live somewhere other than their own families' home.
Youth (grade 8, 10, 12) whose mother has less than or equal to a high school education.	13-17	People of color ages 13-17 are 1.45 times as likely as White youth to have a mother who has less than or equal to a high school education.
Mother's education level is higher than high school at time of child's birth	18-34	People of color ages 18-34 are 0.81 times as likely as White mothers to have an education level higher than high school at time of child's birth.
Civilian women report smoking during pregnancy	18-34	People of color ages 18-34 are 4.5 times as likely as Hispanic women to report smoking during pregnancy.
Civilian women start prenatal care in the first trimester	18-34	People of color ages 18-34 are 0.83 times as likely as White women to start prenatal care in the first trimester.
Death rate per 100,000 residents	35-64	People of color ages 35-64 are 1.87 times as likely as Hispanics to die.
Suicide rate per 100,000 residents	35-64	People of color ages 35-64 are 3.15 times as likely as Hispanics to die by suicide.
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	65+	People of color age 65+ are 0.4 times as likely as White people to be hospitalized for a fall related incident (fatal and nonfatal).
Adults report their general health is excellent, very good, or good during the past 30 days	NS	People of color ages 18+ are 0.9 times as likely as White adults to report their general health is excellent, very good, or good during the past 30 days.
Drug-related death rate per 100,000 residents	NS	People of color are 3.94 times as likely as Hispanics to die for drug-related reasons.
Adults report currently smoking	NS	People of color ages 18+ are 1.99 times as likely as Hispanic adults to report currently smoking.
HISPANIC OR LATINO		
Children age 3-4 enrolled in early education programs	0-4	Hispanic children ages 3-4 are 0.54 times as likely as White children to be enrolled in early education programs.
Youth (grade 8, 10, 12) report having an adult to turn to for help when feeling sad or hopeless	13-17	Hispanics ages 13-17 are 0.9 times as likely as White youth to report having an adult to turn to for help when feeling sad or hopeless.
Youth (grades 8, 10, 12) report parent(s) do not set clear rules	13-17	Hispanics ages 13-17 are 1.3 times as likely as White youth to report having parent(s) who do not set clear rules.
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	Hispanics ages 13-17 are 0.88 times as likely as White youth to report opportunities for prosocial involvement in the family setting.
High school graduation rate (5-year cohort)	13-17	Hispanics ages 13-17 are 0.91 times as likely as White students to graduate high school (5-year cohort).

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
HISPANIC OR LATINO (continued)		
Youth (grade 8, 10, 12) report drinking no sugary beverages in the past 7 days at school	13-17	Hispanics ages 13-17 are 0.92 times as likely as White youth to report drinking no sugary beverages in the past 7 days at school.
Youth (grade 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	Hispanics ages 13-17 are 0.81 times as likely as White youth to report engaging in 1 or more hours of physical activity 5 or more days per week.
Youth (grade 8, 10, 12) report 3 hours or less of screen time for fun on school days	13-17	Hispanics ages 13-17 are 0.84 times as likely as White youth to report 3 hours or less of screen time for fun on school days.
Youth (grade 8, 10, 12) report using alcohol in the past 30 days	13-17	Hispanics ages 13-17 are 1.91 times as likely as White youth to report using alcohol in the past 30 days.
Youth (grade 8, 10, 12) report using marijuana in the past 30 days	13-17	Hispanics ages 13-17 are 1.42 times as likely as White youth to report using marijuana in the past 30 days.
Youth (grade 8, 10, 12) at a normal weight (between the 5th and 95th percentile for BMI)	13-17	Hispanics ages 13-17 are 0.84 times as likely as White youth to be at a normal weight (between the 5th and 95th percentile for BMI).
Youth (grade 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	Hispanics ages 13-17 are 1.37 times as likely as White youth to report seriously considering attempting suicide during the past 12 months.
Youth (grade 8, 10, 12) who live somewhere other than their own families' home.	13-17	Hispanics ages 13-17 are 1.47 times as likely as White youth to live somewhere other than their own families' home.
Youth (grade 8, 10, 12) whose mother has less than or equal to a high school education.	13-17	Hispanics ages 13-17 are 2.65 times as likely as White youth to have a mother who has less than or equal to a high school education.
Mother's education level is higher than high school at time of child's birth	18-34	Hispanics ages 18-34 are 0.5 times as likely as White mothers to have an education level higher than high school at time of child's birth.
Civilian adults report having health insurance	18-34	Hispanics ages 18-34 are 0.82 times as likely as White adults to report having health insurance.
Civilian women start prenatal care in the first trimester	18-34	Hispanics ages 18-34 are 0.9 times as likely as White women to start prenatal care in the first trimester.
Mother's education level is higher than high school at time of child's birth.	35-64	Hispanics ages 35-64 are 0.25 times as likely as White mothers to have an education level higher than high school at time of child's birth.
Civilian adults report having health insurance.	35-64	Hispanics ages 35-64 are 0.74 times as likely as White adults to report having health insurance.
Older adults (age 65 and older) living below 100% of poverty	65+	Hispanics age 65+ are 2.66 times as likely as White adults to be living below 100% of poverty.
Civilian adults report having health insurance..	65+	Hispanics age 65+ are 0.94 times as likely as White adults to report having health insurance.
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents..	65+	Hispanics age 65+ are 0.81 times as likely as White people to be hospitalized for fall related injuries (fatal and nonfatal).
Residents living below 100% of poverty	NS	Hispanics are 2.67 times as likely as White people to be living below 100% of poverty.
Adults (age 25 and older) with more than a high school education	NS	Hispanics ages 25+ are 0.4 times as likely as White adults to have more than a high school education.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
HISPANIC OR LATINO (continued)		
Adults report their general health is excellent, very good, or good during the past 30 days	NS	Hispanics ages 18+ are 0.81 times as likely as White adults report their general health is excellent, very good, or good during the past 30 days.
Adults who reported doing physical activity or exercise during the past 30 days other than their regular job	NS	Hispanics ages 18+ are 0.87 times as likely as White adults to report doing physical activity or exercise during the past 30 days other than their regular job.
Adults who are obese	NS	Hispanics ages 18+ are 2.06 times as likely as people of color to be obese.
WHITE		
Youth (grade 8, 10, 12) report being bullied in the last month	13-17	White youth ages 13-17 are 1.42 times as likely as Hispanic youth to report being bullied in the last month.
Youth (grade 8, 10, 12) report smoking tobacco in the past 30 days	13-17	White youth ages 13-17 are 1.23 times as likely as Hispanic youth to report smoking tobacco in the past 30 days.
Civilian women report smoking during pregnancy	18-34	White women ages 18-34 are 4.4 times as likely as Hispanic women to report smoking during pregnancy.
Suicide-related hospitalization (nonfatal) rate per 100,000 residents	18-34	White people ages 18-34 are 4.36 times as likely as Hispanics to be hospitalized for nonfatal suicide-related incidents.
Suicide rate per 100,000 residents	18-34	White people ages 18-34 are 2.46 times as likely as Hispanics to die by suicide.
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	18-34	White people ages 18-34 are 2.32 times as likely as people of color to be hospitalized for a fall (fatal and nonfatal).
Suicide-related hospitalization (nonfatal) rate per 100,000 residents	35-64	White people ages 35-64 are 3.78 times as likely as Hispanics to be hospitalized for nonfatal suicide-related incidents.
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	35-64	White people ages 35-64 are 2.01 times as likely as Hispanics to be hospitalized for a fall (fatal and nonfatal).
Death rate per 100,000 residents	35-64	White people ages 35-64 are 2.54 times as likely as Hispanics to die.
Suicide rate per 100,000 residents	35-64	White people ages 35-64 are 6.17 times as likely as Hispanics to die by suicide.
Alzheimer's death rate per 100,000 residents	65+	White people age 65+ are 2.2 times as likely as Hispanics to die of Alzheimer's disease.
Civilian adults (age 16 and older) currently employed	NS	White people ages 16+ are 0.91 times as likely as Hispanics to be currently employed.
Drug-related death rate per 100,000 residents	NS	White people are 5.6 times as likely as Hispanics to die of drug-related causes.
Adults ever told by a health care provider that they have cardiovascular disease	NS	White adults ages 18+ are 2.7 times as likely as Hispanics to have ever been told by a health care provider that they have cardiovascular disease.
Adults report currently smoking	NS	White people ages 18+ are 1.73 times as likely as Hispanics to report currently smoking.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
WHITE (continued)		
Adults who are obese	NS	White adults ages 18+ are 1.74 times as likely as people of color to be obese.
LGBTQ		
Youth (grade 8, 10, 12) report being bullied in the last month	13-17	LGBTQ youth ages 13-17 are 2 times as likely as straight youth to report being bullied in the last month.
Youth (grade 8, 10, 12) report having an adult to turn to for help when feeling sad or hopeless	13-17	LGBTQ youth ages 13-17 are 0.82 times as likely as straight youth to report having an adult to turn to for help when feeling sad or hopeless.
Youth (grades 8, 10, 12) report ever being physically hurt on purpose by an adult	13-17	LGBTQ youth ages 13-17 are 1.93 times as likely as straight youth report ever being physically hurt on purpose by an adult.
Youth (grades 8, 10, 12) report parent(s) do not set clear rules	13-17	LGBTQ youth ages 13-17 are 1.8 times as likely as straight youth report having parent(s) who do not set clear rules.
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	LGBTQ youth ages 13-17 are 0.71 times as likely as straight youth to report opportunities for prosocial involvement in the family setting.
Youth (grade 8, 10, 12) report eating 5 or more fruits/vegetables daily	13-17	LGBTQ youth ages 13-17 are 1.26 times as likely as straight youth to report eating 5 or more fruits/vegetables daily.
Youth (grade 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	LGBTQ youth ages 13-17 are 0.78 times as likely as straight youth to report engaging in 1 or more hours of physical activity 5 or more days per week.
Youth (grade 8, 10, 12) report smoking tobacco in the past 30 days	13-17	LGBTQ youth ages 13-17 are 2.91 times as likely as straight youth to report smoking tobacco in the past 30 days.
Youth (grade 8, 10, 12) report using electronic cigarettes in the past 30 days	13-17	LGBTQ youth ages 13-17 are 1.69 times as likely as straight youth to report using electronic cigarettes in the past 30 days.
Youth (grade 8, 10, 12) report using alcohol in the past 30 days	13-17	LGBTQ youth ages 13-17 are 1.58 times as likely as straight youth to report using alcohol in the past 30 days.
Youth (grade 8, 10, 12) report using marijuana in the past 30 days	13-17	LGBTQ youth ages 13-17 are 1.75 times as likely as straight youth to report using marijuana in the past 30 days.
Youth (grade 8, 10, 12) report having had a dental checkup, exam, or cleaning in the past 12 months	13-17	LGBTQ youth ages 13-17 are 0.88 times as likely as straight youth to report having had a dental checkup, exam, or cleaning in the past 12 months.
Youth (grade 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	LGBTQ youth ages 13-17 are 2.84 times as likely as straight youth to report seriously considering attempting suicide during the past 12 months.
Youth (grade 8,10,12) who live somewhere other than their own families' home.	13-17	LGBTQ youth ages 13-17 are 2.76 times as likely as straight youth to live somewhere other than their own families' home.
Youth (grade 8, 10, 12) who have been purposefully hurt by a boy/girlfriend	13-17	LGBTQ youth ages 13-17 are 2.79 times as likely as straight youth to have been purposefully hurt by a boy/girlfriend.
Youth (grade 8, 10, 12) who did not use a condom during last sexual intercourse.	13-17	LGBTQ youth ages 13-17 are 1.33 times as likely as straight youth to not use a condom during last sexual intercourse.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION		
INDICATOR	AGE	STATEMENT
STRAIGHT		
Adults ever told by a health care provider that they have cardiovascular disease	NS	Straight adults ages 18+ are 1.91 times as likely as LGBTQ adults to have ever told by a health care provider that they have cardiovascular disease.

Data Table

The data presented in this table is for all the indicators that showed any degree of statistical significance, regardless of whether it was highlighted on the *Key Findings* section.

Things to know when reading this table:

- There are some instances where data had to be omitted from this report to comply with HIPAA laws regarding low number counts. These instances will have a “low count” value instead of the actual numbers. Since the low count was the numerator, not the denominator, the population size was still great enough to validate the rates presented in this report.
- If an indicator is preceded by an asterisk (*), this indicates there was a statistically significant difference between the interest population group and a different population group not shown on this table due to formatting constraints. For example, the indicator “Youth report being bullied in the last month” under the population group People of Color illustrates a disparity that exists between Youth of Color and Hispanic/Latino youth, not between Youth of Color and original reference group of White youth. If someone is interested in reviewing the full numbers from this table, please contact Benton-Franklin Health District using the contact information listed in this report.

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
FEMALES										
	FEMALE						MALE			
Youth (grade 8, 10, 12) report being bullied in the last month	13-17	2016	1049/4067	25.8%	24.5%	27.2%	734/3983	18.4%	17.3%	19.7%
Youth (grades 8, 10, 12) report ever being physically hurt on purpose by an adult	13-17	2016	449/1828	24.6%	22.6%	26.5%	373/1745	21.4%	19.5%	23.3%
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	2016	1030/1812	56.8%	54.6%	59.1%	1061/1713	61.9%	59.6%	64.2%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
FEMALES (continued)										
	FEMALE						MALE			
Youth (grade 8, 10, 12) report eating 5 or more fruits/vegetables daily	13-17	2016	343/2023	17.0%	15.3%	18.6%	437/1946	22.5%	20.6%	24.3%
Youth (grade 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	2016	1002/2021	49.6%	47.4%	51.8%	1213/1960	61.9%	59.7%	64.0%
Youth (grade 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	2016	267/2060	13.0%	11.5%	14.4%	139/2010	6.9%	5.8%	8.0%
Suicide-related hospitalization (nonfatal) rate per 100,000 residents	35-64	2011-15	136/195627	69.5	57.8	81.1	83/200024	41.5	32.6	50.4
Older adults (age 65 and older) living below 100% of poverty	65+	2016	1566/17177	9.1%	8.7%	9.5%	790/15009	5.3%	4.9%	5.6%
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents.	65+	2014-15	1954/66648	2931.8	2803.7	3068.4	1068/58625	1821.7	1713.5	1930.0
Alzheimer's death rate per 100,000 residents	65+	2012-16	579/85204	679.5	624.4	738.2	234/75467	310.1	270.4	349.7
Residents living below 100% of poverty	NS	2016	21847/134586	16.2%	16.0%	16.4%	17969/136536	13.2%	13.0%	13.3%
Civilian adults (age 16 and older) currently employed	NS	2016	50307/76546	65.7%	65.4%	66.1%	62292/79795	78.1%	77.8%	78.4%
Adults report mental distress (14 or more days of poor mental health during the past 30 days)	NS	2011-16	174/1511	13.9%	11.5%	16.7%	77/1200	7.2%	5.3%	9.7%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
FEMALES (continued)										
	FEMALE						MALE			
Adults report their general health is excellent, very good, or good during the past 30 days	NS	2011-16	1233/2734	81.1%	78.1%	83.8%	1024/1207	85.2%	82.3%	87.8%
MALES										
	MALE						FEMALE			
High school graduation rate (5-year cohort)	13-17	2015-16	1475/1866	79.0%	77.2%	80.9%	1608/1873	85.9%	84.3%	87.4%
Youth (grade 8, 10, 12) report 3 hours or less of screen time for fun on school days	13-17	2016	825/1945	42.4%	40.2%	44.6%	948/1997	47.5%	45.3%	49.7%
Youth (grade 8, 10, 12) report using electronic cigarettes in the past 30 days	13-17	2016	303/1999	15.2%	13.6%	16.7%	257/2058	12.5%	11.1%	13.9%
Youth (grade 8, 10, 12) report having had a dental checkup, exam, or cleaning in the past 12 months	13-17	2016	1456/1738	83.8%	82.0%	85.5%	1590/1828	87.0%	85.4%	88.5%
Youth (grade 8, 10, 12) at a normal weight (between the 5th and 95th percentile for BMI)	13-17	2016	1135/1820	62.4%	60.1%	64.6%	1276/1825	69.9%	67.8%	72.0%
Civilian adults report having health insurance	18-34	2016	23180/31899	72.7%	72.2%	73.2%	23875/30886	77.3%	76.8%	77.8%
Diabetes-related hospitalization (fatal and nonfatal) rate per 100,000 residents	18-34	2015	100/64336	155.4	125.0	185.9	66/60957	108.3	82.2	134.4
Death rate per 100,000 residents	18-34	2015	59/31962	184.6	137.5	231.7	**Low Count**	66.0	37.1	95.0
Suicide rate per 100,000 residents	18-34	2007-16	72/309245	23.3	17.9	28.7	**Low Count**	4.1	1.8	6.4

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
MALES (continued)										
	MALE						FEMALE			
Civilian adults report having health insurance	35-64	2016	41118/49082	83.8%	83.4%	84.1%	42134/48483	86.9%	86.6%	87.2%
Diabetes-related hospitalization (fatal and nonfatal) rate per 100,000 residents	35-64	2015	218/101458	214.9	186.4	243.4	116/99043	117.1	95.8	138.4
Heart disease hospitalization (fatal and nonfatal) rate per 100,000 residents	35-64	2011-15	825/101458	813.1	757.9	868.4	417/99043	421.0	380.7	461.4
Suicide rate per 100,000 residents	35-64	2007-16	125/483199	25.9	21.3	30.4	43/471064	9.1	6.4	11.9
Diabetes-related hospitalization (fatal and nonfatal) rate per 100,000 residents	65+	2014-15	90/31004	290.3	230.4	350.2	48/34838	137.8	98.8	176.7
Heart disease hospitalization (fatal and nonfatal) rate per 100,000 residents	65+	2014-15	1371/31004	4422.0	4193.2	4650.9	1180/34838	3387.1	3197.1	3577.1
Suicide rate per 100,000 residents	65+	2007-16	50/132582	37.7	27.3	48.2	579/85204	4.6	0.0	9.1
Adults (age 25 and older) with more than a high school education	NS	2016	50977/85374	59.7%	59.4%	60.0%	51130/84943	60.2%	59.9%	60.5%
Adults ever told by a health care provider that they have cardiovascular disease	NS	2011-16	89/1197	4.1%	3.0%	5.6%	50/1516	2.1%	1.4%	3.1%
Adults report currently smoking	NS	2011-16	153/1175	17.8%	14.8%	21.3%	169/1496	12.9%	10.5%	15.7%
PEOPLE OF COLOR										
	PEOPLE OF COLOR						WHITE			
Babies born at low birth weight (less than 2500 grams)	0-4	2014-16	65/813	8.0%	6.1%	9.9%	390/6451	6.0%	5.5%	6.6%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
PEOPLE OF COLOR (continued)										
	PEOPLE OF COLOR						WHITE			
Children age 3-4 enrolled in early education programs	0-4	2016	35/669	5.2%	3.5%	6.9%	372/3848	9.7%	8.7%	10.6%
*Youth (grade 8, 10, 12) report being bullied in the last month	13-17	2016	430/1620	26.5%	24.5%	28.8%	826/3391	24.4%	22.9%	25.8%
Youth (grade 8, 10, 12) report having an adult to turn to for help when feeling sad or hopeless	13-17	2016	389/528	73.7%	69.9%	77.4%	969/1170	82.8%	80.7%	85.0%
Youth (grades 8, 10, 12) report ever being physically hurt on purpose by an adult	13-17	2016	194/711	27.3%	24.0%	30.6%	336/1567	21.4%	19.4%	23.5%
Youth (grades 8, 10, 12) report parent(s) do not set clear rules	13-17	2016	113/693	16.3%	13.6%	19.1%	192/1568	12.2%	10.6%	13.9%
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	2016	383/689	55.6%	51.9%	59.3%	990/1557	63.6%	61.2%	66.0%
High school graduation rate (5-year cohort)	13-17	2015-16	205/254	80.7%	75.9%	85.6%	1734/2020	85.8%	84.3%	87.4%
Youth (grade 8, 10, 12) report eating 5 or more fruits/vegetables daily	13-17	2016	180/793	22.7%	19.8%	25.6%	296/1685	17.6%	15.7%	19.4%
Youth (grade 8, 10, 12) report drinking no sugary beverages in the past 7 days at school	13-17	2016	405/803	50.4%	47.0%	53.9%	941/1695	55.5%	53.2%	57.9%
Youth (grade 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	2016	446/795	56.1%	52.7%	59.6%	1025/1685	60.8%	58.5%	63.2%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
PEOPLE OF COLOR (continued)										
	PEOPLE OF COLOR						WHITE			
Youth (grade 8, 10, 12) report 3 hours or less of screen time for fun on school days	13-17	2016	342/784	43.6%	40.2%	47.1%	816/1671	48.8%	46.4%	51.2%
*Youth (grade 8, 10, 12) report smoking tobacco in the past 30 days	13-17	2016	117/1573	7.4%	6.1%	8.7%	215/3345	6.4%	5.6%	7.3%
Youth (grade 8, 10, 12) report using electronic cigarettes in the past 30 days	13-17	2016	137/813	16.9%	14.3%	19.4%	229/1706	13.4%	11.8%	15.0%
Youth (grade 8, 10, 12) report using marijuana in the past 30 days	13-17	2016	276/1564	17.6%	15.8%	19.5%	420/3343	12.6%	11.4%	13.7%
Youth (grade 8, 10, 12) report having had a dental checkup, exam, or cleaning in the past 12 months	13-17	2016	558/702	79.5%	76.5%	82.5%	1379/1572	87.7%	86.1%	89.3%
Youth (grade 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	2016	112/821	13.6%	11.3%	16.0%	132/1706	7.7%	6.5%	9.0%
Youth (grade 8, 10, 12) who live somewhere other than their own families' home.	13-17	2016	119/1570	7.6%	6.3%	8.9%	129/3329	3.9%	3.2%	4.5%
Youth (grade 8, 10, 12) whose mother has less than or equal to a high school education.	13-17	2016	506/1205	42.0%	39.2%	44.8%	840/2899	29.0%	27.3%	30.6%
Mother's education level is higher than high school at time of child's birth	18-34	2016	136/238	57.1%	50.9%	63.4%	563/1597	70.4%	68.2%	72.7%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
PEOPLE OF COLOR (continued)										
	PEOPLE OF COLOR						WHITE			
*Civilian women report smoking during pregnancy	18-34	2016	29/237	12.2%	8.1%	16.4%	215/1798	12.0%	10.5%	13.5%
Civilian women start prenatal care in the first trimester	18-34	2016	148/218	67.9%	61.7%	74.1%	1332/1630	81.7%	79.8%	83.6%
*Death rate per 100,000 residents	35-64	2016	27/7134	378.5	236.0	521.0	369/71734	514.4	462.0	566.8
*Suicide rate per 100,000 residents	35-64	2007-16	**Low Count**	11.3	2.9	19.7	154/696966	22.1	18.6	25.6
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	65+	2014-15	56/5808	964.2	712.9	1215.5	2626/109303	2402.5	2311.7	2493.3
Adults report their general health is excellent, very good, or good during the past 30 days	NS	2011-16	118/156	79.5%	70.5%	86.4%	1867/2185	87.9%	85.9%	89.7%
*Drug-related death rate per 100,000 residents	NS	2012-16	**Low Count**	12.2	5.0	19.5	148/850448	17.4	14.6	20.2
*Adults report currently smoking	NS	2011-16	27/155	19.5%	12.7%	29.3%	262/2143	17.0%	14.6%	19.7%
HISPANIC OR LATINO										
	HISPANIC OR LATINO						WHITE			
Children age 3-4 enrolled in early education programs	0-4	2016	229/4374	5.2%	4.6%	5.9%	372/3848	9.7%	8.7%	10.6%
Youth (grade 8, 10, 12) report having an adult to turn to for help when feeling sad or hopeless	13-17	2016	653/873	74.8%	71.9%	77.7%	969/1170	82.8%	80.7%	85.0%
Youth (grades 8, 10, 12) report parent(s) do not set clear rules	13-17	2016	201/1266	15.9%	13.9%	17.9%	192/1568	12.2%	10.6%	13.9%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
HISPANIC OR LATINO (continued)										
	HISPANIC OR LATINO						WHITE			
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	2016	700/1259	55.9%	53.2%	58.6%	990/1557	63.6%	61.2%	66.0%
High school graduation rate (5-year cohort)	13-17	2015-16	1144/1465	78.1%	76.0%	80.2%	1734/2020	85.8%	84.3%	87.4%
Youth (grade 8, 10, 12) report drinking no sugary beverages in the past 7 days at school	13-17	2016	754/1479	51.0%	48.4%	53.5%	941/1695	55.5%	53.2%	57.9%
Youth (grade 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	2016	726/1469	49.4%	46.9%	52.0%	1025/1685	60.8%	58.5%	63.2%
Youth (grade 8, 10, 12) report 3 hours or less of screen time for fun on school days	13-17	2016	596/1455	41.0%	38.4%	43.5%	816/1671	48.8%	46.4%	51.2%
Youth (grade 8, 10, 12) report using alcohol in the past 30 days	13-17	2016	610/1897	32.2%	30.1%	34.3%	563/3342	16.8%	15.6%	18.1%
Youth (grade 8, 10, 12) report using marijuana in the past 30 days	13-17	2016	513/2874	17.8%	16.4%	19.2%	420/3343	12.6%	11.4%	13.7%
Youth (grade 8, 10, 12) at a normal weight (between the 5th and 95th percentile for BMI)	13-17	2016	160/1508	59.8%	57.3%	62.2%	1114/1573	70.8%	68.6%	73.1%
Youth (grade 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	2016	160/1508	10.6%	9.1%	12.2%	132/1706	7.7%	6.5%	9.0%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
HISPANIC OR LATINO (continued)										
	HISPANIC OR LATINO						WHITE			
Youth (grade 8, 10, 12) who live somewhere other than their own families' home	13-17	2016	165/2897	5.7%	4.9%	6.5%	129/3329	3.9%	3.2%	4.5%
Youth (grade 8, 10, 12) whose mother has less than or equal to a high school education	13-17	2016	1637/2132	76.8%	75.0%	78.6%	840/2899	29.0%	27.3%	30.6%
Mother's education level is higher than high school at time of child's birth	18-34	2016	563/1597	35.3%	32.9%	37.6%	1268/1800	70.4%	68.3%	72.6%
Civilian adults report having health insurance	18-34	2016	31591/34751	74.6%	74.1%	75.0%	31591/25751	90.9%	90.6%	91.3%
Civilian women start prenatal care in the first trimester	18-34	2016	1127/1528	73.8%	71.6%	76.0%	1332/1630	81.7%	79.8%	83.6%
Mother's education level is higher than high school at time of child's birth.	35-64	2016	50/245	20.4%	15.4%	25.5%	237/285	83.2%	78.8%	87.5%
Civilian adults report having health insurance.	35-64	2016	17435/24568	71.0%	70.4%	71.5%	66072/69049	95.7%	95.5%	95.8%
Older adults (age 65 and older) living below 100% of poverty	65+	2016	452/2616	17.3%	15.8%	18.7%	1704/27729	6.5%	6.2%	6.8%
Civilian adults report having health insurance	65+	2016	2365/2514	94.1%	93.2%	95.0%	29680/29680	100.0%	######	100.0%
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	65+	2014-15	197/10162	1938.6	1670.5	2206.7	2626/109303	2402.5	2311.7	2493.3
Residents living below	NS	2016	21066/82979	25.4%	25.1%	25.7%	16132/169390	9.5%	9.4%	9.7%

100% of poverty										

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
HISPANIC OR LATINO (continued)										
	HISPANIC OR LATINO						WHITE			
Adults (age 25 and older) with more than a high school education	NS	2016	10739/38406	28.0%	27.5%	28.4%	84011/120723	69.6%	69.3%	69.8%
Adults report their general health is excellent, very good, or good during the past 30 days	NS	2011-16	248/359	70.9%	64.8%	76.3%	1867/2185	87.9%	85.9%	89.7%
Adults who reported doing physical activity or exercise during the past 30 days other than their regular job	NS	2011, 13 & 15	251/352	71.0%	64.8%	76.5%	1712/2129	81.4%	78.9%	83.7%
*Adults who are obese	NS	2011-16	108/299	35.5%	29.1%	42.5%	632/2051	30.1%	27.5%	32.8%
WHITE										
	WHITE						HISPANIC OR LATINO			
Youth (grade 8, 10, 12) report being bullied in the last month	13-17	2016	826/3391	24.4%	22.9%	25.8%	510/2979	17.1%	15.8%	18.5%
Youth (grade 8, 10, 12) report smoking tobacco in the past 30 days	13-17	2016	215/3345	6.4%	5.6%	7.3%	151/2893	5.2%	4.4%	6.0%
Civilian women report smoking during pregnancy	18-34	2016	215/1798	12.0%	10.5%	13.5%	44/1619	2.7%	1.9%	3.5%
Suicide-related hospitalization (nonfatal) rate per 100,000 residents	18-34	2011-15	147/137937	104.4	87.4	121.4	23/96119	23.9	14.2	33.7
Suicide rate per 100,000 residents	18-34	2007-16	63/338268	18.6	14.0	23.2	**Low Count**	7.6	4.0	11.2

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
WHITE (continued)										
	WHITE						HISPANIC OR LATINO			
*Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	18-34	2011-15	116/137937	84.1	68.8	99.4	65/96119	67.6	51.2	84.1
Suicide-related hospitalization (nonfatal) rate per 100,000 residents	35-64	2011-15	176/284018	62.0	52.8	71.1	**Low Count**	16.4	7.8	25.0
Fall-related hospitalization (fatal and nonfatal) rate per 100,000 residents	35-64	2011-15	661/284018	232.7	215.0	250.5	99/85334	116.0	93.2	138.9
Death rate per 100,000 residents	35-64	2016	369/71734	514.4	462.0	566.8	48/23666	202.8	145.5	260.1
Suicide rate per 100,000 residents	35-64	2007-16	154/696966	22.1	18.6	25.6	**Low Count**	3.6	0.9	6.2
*Suicide rate per 100,000 residents	65+	2007-16	56/251512	22.3	16.4	28.1	**Low Count**	4.6	0.1	25.6
Alzheimer's death rate per 100,000 residents	65+	2012-16	760/139744	543.9	505.3	582.4	33/13352	247.2	162.9	331.4
Civilian adults (age 16 and older) currently employed	NS	2016	80314/138183	58.1%	57.9%	58.4%	33429/52201	64.0%	63.6%	64.5%
Drug-related death rate per 100,000 residents	NS	2012-16	148/850448	17.4	14.6	20.2	13/418320	3.1	1.4	4.8
Adults ever told by a health care provider that they have cardiovascular disease	NS	2011-16	128/2170	4.0%	3.1%	5.1%	**Low Count**	1.5%	0.6%	3.8%
Adults report currently smoking	NS	2011-16	262/2143	17.0%	14.6%	19.7%	32/341	9.8%	6.2%	15.3%
*Adults who are obese	NS	2011-16	632/2051	30.1%	27.5%	32.8%	108/299	35.5%	29.1%	42.5%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
LGBTQ										
	LGBTQ						STRAIGHT			
Youth (grade 8, 10, 12) report being bullied in the last month	13-17	2016	226/564	40.1%	36.0%	44.1%	627/3134	20.0%	18.6%	21.4%
Youth (grade 8, 10, 12) report having an adult to turn to for help when feeling sad or hopeless	13-17	2016	132/197	67.0%	60.4%	73.6%	831/1019	81.6%	79.2%	83.9%
Youth (grades 8, 10, 12) report ever being physically hurt on purpose by an adult	13-17	2016	105/271	38.7%	32.9%	44.5%	319/1586	20.1%	18.1%	22.1%
Youth (grades 8, 10, 12) report parent(s) do not set clear rules	13-17	2016	61/284	21.5%	16.7%	26.3%	182/1526	11.9%	10.3%	13.6%
Youth (grades 8, 10, 12) report opportunities for prosocial involvement in the family setting	13-17	2016	127/284	44.7%	38.9%	50.5%	958/1524	62.9%	60.4%	65.3%
Youth (grade 8, 10, 12) report eating 5 or more fruits/vegetables daily	13-17	2016	70/275	25.5%	20.3%	30.6%	319/1577	20.2%	18.2%	22.2%
Youth (grade 8, 10, 12) report engaging in 1 or more hours of physical activity 5 or more days per week	13-17	2016	126/275	45.8%	39.9%	51.7%	941/1597	58.9%	56.5%	61.3%
Youth (grade 8, 10, 12) report smoking tobacco in the past 30 days	13-17	2016	85/563	15.1%	12.1%	18.1%	162/3126	5.2%	4.4%	6.0%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
LGBTQ (continued)										
	LGBTQ						STRAIGHT			
Youth (grade 8, 10, 12) report using electronic cigarettes in the past 30 days	13-17	2016	55/277	19.9%	15.2%	24.6%	188/1599	11.8%	10.2%	13.3%
Youth (grade 8, 10, 12) report using alcohol in the past 30 days	13-17	2016	148/564	26.2%	22.6%	29.9%	518/3120	16.6%	15.3%	17.9%
Youth (grade 8, 10, 12) report using marijuana in the past 30 days	13-17	2016	123/562	21.9%	18.5%	25.3%	391/3122	12.5%	11.4%	13.7%
Youth (grade 8, 10, 12) report having had a dental checkup, exam, or cleaning in the past 12 months	13-17	2016	191/247	77.3%	72.1%	82.5%	1305/1482	88.1%	86.4%	89.7%
Youth (grade 8, 10, 12) report seriously considering attempting suicide during the past 12 months	13-17	2016	66/275	24.0%	19.0%	29.0%	135/1598	8.4%	7.1%	9.8%
Youth (grade 8, 10, 12) who live somewhere other than their own families' home	13-17	2016	60/562	10.7%	8.1%	13.2%	121/3123	3.9%	3.2%	4.6%
Youth (grade 8, 10, 12) who have been purposefully hurt by a boy/girlfriend	13-17	2016	34/150	22.7%	16.0%	29.4%	65/800	8.1%	6.2%	10.0%
Youth (grade 8, 10, 12) who did not use a condom during last sexual intercourse.	13-17	2016	59/106	55.7%	46.2%	65.1%	152/362	42.0%	36.9%	47.1%

DATA TABLE OF STATISTICALLY SIGNIFICANT DISPARITIES BY SUBGROUP POPULATION										
INDICATOR	AGE	YEAR	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER	NUMBER /TOTAL	ESTIMATE	LOWER	UPPER
STRAIGHT										
	STRAIGHT						LGBTQ			
Adults ever told by a health care provider that they have cardiovascular disease	NS	2011-16	108/1971	3.6%	2.7%	4.8%	23/557	1.9%	1.2%	3.1%

Data Sources

The data used for analysis in this report was gathered from multiple sources. This section identifies the sources used to compile this report along with a description of each source as described on their respective websites.

U.S. Census and American Community Survey (ACS)
The Census and American Community Survey (ACS) collect data on population and housing information. The Census is conducted every 10 years and the ACS is conducted annually.

Behavioral Risk Factor Surveillance System (BRFSS)
Behavioral Risk Factor Surveillance System (BRFSS) is a national system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

Community Health Assessment Tool (CHAT)
CHAT provides a secure, online query system for population health-based data sets maintained by the Washington State Department of Health. CHAT is restricted for use by assessment staff at local health jurisdictions, Washington State Department of Health, tribal health agencies, and other state government agencies engaged in public health activities. The tool allows users to conduct analyses for community health assessment. CHAT contains detailed information on a series of topics with statistics related to the data topic. The data topics in CHAT cover a variety of Washington state population health-based datasets that include reproductive services and information, birth risk factors, communicable diseases, sexually transmitted diseases, cancer incidence, hospitalizations for illness and injuries, deaths and fatal injuries, life expectancy, infant death and risk factors, and Washington State Opioid Quarterly Report.

Healthy Youth Survey (HYS)
The Healthy Youth Survey is a collaborative effort of the Office of the Superintendent of Public Instruction, the Department of Health, the Department of Social and Health Service's Division of Behavioral Health and Recovery, and the Liquor and Cannabis Board. The information from the Healthy Youth Survey can be used to identify trends in the patterns of behavior over time. Since October 2002, every two years, students in grade 6,8,10, and 12 answered questions about safety and violence, physical activity and diet, alcohol, tobacco and other drug use, and related risk and protective factors.

Office of the Superintendent of Public Instruction (OSPI)
Washington State OSPI maintains a couple data collection tools.

- The Education Data System is a centralized suite of web-based applications regarding educational data. It is used by state agencies, educational service districts (ESDs), school districts, schools, teachers, teaching certificate applicants, non-profit organizations, and businesses for a variety of purposes related to education in the State of Washington.
- The Comprehensive Education Data and Research System (CEDARS) is a longitudinal data warehouse of educational data. Districts report data on courses, students, and teachers. Course data includes standardized state course codes. Student data includes demographics, enrollment information, schedules, grades, and program participation. Teacher data includes demographics, certifications, and schedules.

Other References

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention (June 2016) ACE Study.
2. Bergland, C. (Sep 2018) 5 Factors Linked to Higher Risk of Early Life Adversity. *Psychology Today*. Retrieved from https://www.psychologytoday.com/us/blog/the-athletes-way/201809/5-factors-linked-higher-risk-early-life-adversity
3. The Centers for Disease Control and Prevention. (May 2012). Lesson 3: Measures of Risk. In *Principles of Epidemiology in Public Health Practice* (3rd ed.). Atlanta, Georgia: U.S. Department of Health and Human Services.

Glossary of Terms

Adverse Childhood Experiences (ACEs): stressful and traumatic events experienced in early childhood that can have lasting impact on a person's future health. The foundational research on ACEs indicates a wide range of chronic health conditions and shorter lifespan are associated with greater number of ACEs experienced in childhood.

Health Equity: Works to optimize conditions so that everyone in the community has the opportunity to attain their highest level of health and achieve positive health outcomes.

Health Disparities: Differences in health status between people related to Social Determinants of Health, such as race, gender, income, or geographic region. Health disparities are one way to measure progress toward achieving health equity; fewer Health Disparities mean greater Health Equity.

Interest Population Group: The demographic population group that is compared to the reference population group in order to check for disparities.

Reference/Comparative Population Group: The baseline demographic population group to which the interest population groups are compared against.

Relative Risk Ratio: The comparison of risk level of certain health factors or outcomes for one group with the risk level among another group.

Social Determinants of Health (SDOH): Socially-constructed factors that influence health such as housing, education, healthcare, public safety, and food access. Race, culture, and gender identity are forces in determining how these social determents are distributed.

Acknowledgments

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This report was adapted from a model by Kitsap Public Health District. Their 2017 Disparity Report can be found on their website:
http://kitsappublichealth.org/information/data_Indicators.php

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PUBLIC
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